Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

GABRIEL LOPEZ MD
5734 SPOHN DRIVE
CORPUS CHRISTI TEXAS 78414

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-06-7526-01

MFDR Date Received

August 15, 2006

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Rationale A: Physician saw the pt for an office visit for his compensable injury. According to the TWCC Fast Facts, if the injury is compensable, the carrier is liable for all reasonable and necessary medical costs of health care to treat the compensable injury. Rationale B: Per Medicare's reimbursement guidelines, injectables are separately reimbursable (Medicare Carrier Manual Part 3 (Chap II) (sec 2049)."

Amount in Dispute: $3,531.57

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is the carrier's position that a 'properly completed' medical bill or a 'properly completed' request for reconsideration for the charge in this dispute was not received, reduced or denied by this carrier. That this carrier did not receive, reduce, or deny the bill is further supported by the fact the requestor provided NO explanation of benefits with the request for dispute resolution. (See requester's DWC-60 packet) Texas Mutual was not provided the opportunity to respond to the charge in dispute, whether initial bill or request for reconsideration, prior to the requestor submitting its charge(s) to Medical Dispute Resolution (MDR). Texas Mutual believes this is not a proper request for dispute resolution."

Response Submitted by: TEXAS MUTUAL INSURANCE CO

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 21, 2005	99213, 62367, 95991, J2275, J3490, K0735	$3,531.57	$211.55

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. This request for medical fee dispute resolution was received by the Division on August 15, 2006. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on August 22, 2006 to send additional documentation relevant to the fee dispute as set forth in the rule.

2. Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, requires that services not identified in a fee guideline shall be reimbursed at fair and reasonable rates.
3. Texas Labor Code §413.011 requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control.
4. Division rule at 28 TAC §134.202, titled *Medical Fee Guideline*, effective August 1, 2003, sets out the reimbursement for medical treatment.
5. Division rule at 28 TAC §133.307, effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, sets out the procedure for medical fee dispute resolution.
6. Division rule at 28 TAC §133.304, effective July 15, 2000, 25 TexReg 2115, requires the insurance carrier to develop and consistently apply a methodology to determine fair and reasonable reimbursement.
7. The requestor/respondent did not submit copies of EOBs with the medical dispute resolution request. Disputed services will therefore be reviewed according to the applicable fee guidelines.

Issues

1. Did the requestor file the dispute in the manner prescribed by 28 Tex. Administrative Code §133.307?
2. Is the requestor entitled to reimbursement?

Findings

1. Division rule at 28 TAC §133.304(k)(1)(A) requires that if a health care provider "…is dissatisfied with the insurance carrier's final action on a medical bill, the sender may request that the insurance carrier reconsider its action. The sender shall submit… (1) a copy of the medical bill that the health care provider is requesting the insurance carrier to reconsider, (A) clearly marked with the statement, 'REQUEST FOR RECONSIDERATION.' A review of the submitted documentation finds that the medical bill is clearly marked "Request for Reconsideration." The requestor, therefore met the requirements of 28 TAC §133.304(k)(1)(A).
2. Division rule at 28 TAC §133.304(m) states "The sender of a medical bill may request medical dispute resolution in accordance with §133.305 of this title (relating to Medical Dispute Resolution) if the sender of a medical bill has requested reconsideration in accordance with this section and: (1) after reconsideration, the sender is still dissatisfied with the insurance carrier's action on the medical bill; or (2) the sender has not received the insurance carrier's response to the request for reconsideration by the 28th day after the date the request for reconsideration was sent to the insurance carrier." The requestor, therefore met the requirements of 28 TAC §133.304(m).
3. Review of the documentation provided by the requestor finds that the request for dispute resolution was not filed in the manner required by 28 Tex. Admin. Code §133.307. For example, 28 Tex. Admin. Code §133.307 requires the requestor when submitting a request for medical dispute resolution that a copy of each explanation of benefits (EOB) or, if no EOB was received, convincing evidence of carrier receipt of the provider request for an EOB. The requestor and respondent did not submit copies of EOBs with the medical dispute resolution request/response, the disputed services are therefore reviewed according to the applicable fee guidelines.
4. Division rule at 28 TAC §134.202(d) states "In all cases, reimbursement shall be the least of the: (1) MAR amount as established by this rule; (2) health care provider's usual and customary charge; or (3) health care provider's workers" compensation negotiated and/or contracted amount that applies to the billed service(s). Review of the documentation submitted by the requestor supports that the services rendered were billed. Review of Medicare's NCCI Edits reveals no coding conflicts of the HCPC codes billed on September 21, 2005. The Division therefore finds that the requestor is entitled to reimbursement for HCPC codes 99213, 62367, 95991:
   - The MAR amount for HCPCS code 99213 is $61.87
   - The MAR amount for HCPCS code 62367 is $49.59
   - The MAR amount for HCPCS code 95991 is $100.09

   The total recommended amount for the above HCPC codes noted above is $211.55.
5. Division rule at 28 TAC §134.1 requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers" Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."

6. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing

the fee guidelines.

7. Division rule at 28 TAC §134.202(c)(2) states "for Healthcare Common Procedure Coding System (HCPCS) Level II codes, A, E,J, K, and L: (A) 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule; (B) if the code has no published Medicare rate, 125% of the published Texas Medicaid Fee Schedule Durable Medical Equipment/Medical Supplies Report J, for HCPCS; or (C) if neither paragraph (2)(A) nor (2)(B) of this section apply, then is calculated according to paragraph (6) of this subsection."
    - The Division finds that HCPCS codes J3490, J0735 and J2275 do not have a fee listed in Medicare and Medicaid DMEPOS fee schedules.
8. Review of the documentation submitted by the parties to this dispute finds no documentation to support that an amount was pre-negotiated and/or contracted between the provider and carrier for the disputed HCPCS code J3490, J3490 and J0735 therefore, the insurance carrier shall reimburse the provider the fair and reasonable rate in accordance with Division rule at 28 TAC §134.1.
9. Division rule at 28 TAC §133.307(g)(3)(D) requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
    - The requestor did not submit documentation to support the rationale that $3,320.00 was a fair and reasonable rate of reimbursement for HCPCS codes J3490, J0735 and J2275.
    - The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
    - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
    - The requestor does not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, provide for payment that is not in excess of a fee charged for similar treatment of an injured individual of an equivalent standard of living, consider the increased security of payment, or otherwise satisfy the requirements of Texas Labor Code §413.011(d) or Division rule at 28 TAC §134.1.
    - The request for additional reimbursement for HCPCS code J3490 is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended for HCPCS code J3490.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $211.55.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $211.55 plus applicable accrued interest per 28 Texas Administrative Code §134.803 for dates of service prior to 5/2/06, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 15, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.